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No. 93-510

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE TRAVELERS INSURANCE COMPANY AND BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE*

The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area, a division of Group Hospitalization and Medical Services, Inc., a Member of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, by its undersigned attorneys, hereby move the Court for leave, pursuant to Rule 37 of the Rules of the Supreme Court of the United States, to appear as *amici curiae* in the above-captioned proceeding in support of the Petition for Writ of Certiorari of Petitioners Aetna Life Insurance Company and Aetna Health Management. This motion and the accompanying conditionally filed brief is made within the time specified by Rule 37.2. The written consent of Petitioners Aetna Life Insurance Company and

Aetna Health Management accompanies this motion and the proposed brief. Stuart Circle Hospital Corporation has refused to consent to the filing of this brief.

The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area * (collectively the *"amici curiae"*) are health insurance companies that also administer preferred provider organizations ("PPOs"). Together, these companies manage over 50 PPOs, which cover more than 2 million individuals across the United States. The *amici curiae* currently manage PPOs subject to the Employee Retirement Income Security Act of 1974 ("ERISA") in Virginia and throughout the nation. Certain of these PPOs may also be subject to the "any willing provider" statute interpreted by the Fourth Circuit in this case, as well as similar statutes in at least fourteen other states. The *amici curiae* are therefore vitally interested in the judicial interpretation of these statutes.

The *amici curiae* believe that the proper interpretation of ERISA and any-willing-provider statutes, particularly by the United States Supreme Court, is important to the public interest, as well as to PPOs, subscribers, and providers. Improper expansion of state statutes into an area regulated by ERISA can significantly raise the costs of health insurance to all Americans. In the view of the *amici curiae*, their experience in PPO administration and health insurance will be helpful to this Court's examination of this important issue.

Through their proposed submission, the *amici* seek to provide a broad perspective on the statutory interpretation questions by highlighting to this Court the critical and substantial issues at stake. The *amici*'s brief does not duplicate arguments raised by the parties. Rather, it explains the important economic and policy reasons for applying ERISA preemption to any-willing-provider stat-

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* Blue Cross and Blue Shield of the National Capital Area provides coverage as a not-for-profit health services plan.

utes. In particular, the proffered brief demonstrates the benefits conferred upon society by PPOs and the threat posed by any-willing-provider statutes to PPOs.

More generally, as commentators have stressed, an *amicus* is often in a superior position "to focus the court's attention on the broad implications of various possible rulings." Bruce Ennis, *Effective Amicus Briefs*, 33 Cath. U.L. Rev. 603, 608 (1984), *quoted in* Robert L. Stern et al., *Supreme Court Practice* 570-71 (1986).

The *amici curiae*'s request for leave to participate will not disrupt the briefing schedule, undermine the orderly presentation of argument, delay in any way the resolution of this action, or inject new or unrelated questions into this litigation. The accompanying proposed brief is submitted conditionally at this time.

WHEREFORE, The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area respectfully request that this Court grant their motion for leave to file an *amici curiae* brief in support of the Petition for Writ of Certiorari of Petitioners Aetna Life Insurance Company and Aetna Health Management.

Respectfully submitted,

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BRIEF *AMICI CURIAE* OF THE TRAVELERS INSURANCE COMPANY AND BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA IN SUPPORT OF PETITIONERS

Amici Curiae The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area, a division of Group Hospitalization and Medical Services, Inc., a Member of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, hereby support the petition for writ of certiorari of Aetna Life Insurance Company and Aetna Health Management ("Aetna") to review the judgment in this case of the United States Court of Appeals for the Fourth Circuit.

INTEREST OF THE *AMICI CURIAE*

The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area (collectively the "*amici curiae*") are health insurance companies that also administer preferred provider organizations ("PPOs"). Together, these companies manage over 50 PPOs, which cover more than 2 million individuals across the United States. The *amici curiae* currently manage PPOs subject to the Employee Retirement Income Security Act of 1974 ("ERISA") in Virginia and throughout the nation. Certain of these PPOs may also be subject to the "any willing provider" statute interpreted by the Fourth Circuit in this case, as well as similar statutes in at least fourteen other states. The *amici curiae* are therefore vitally interested in the judicial interpretation of these statutes.

INTRODUCTION

The Fourth Circuit's erroneous decision in this case threatens the viability of insurer-administered PPOs, a vital and efficient form of delivering health care services. PPOs directed by insurance companies currently cover over 30 million individuals. Since PPOs were introduced in the early 1980s, their popularity has rapidly increased

because they have proven effective in controlling runaway health care costs while still providing consumer choice. PPOs accomplish these twin goals by using the bargaining power derived from a large subscriber base to negotiate lower prices for their subscribers. These lower prices, in turn, ensure a higher patient volume for the PPO's network of health care providers by creating financial incentives for the subscribers to use the participating providers. In so doing, PPOs benefit all segments of society.

The Virginia any-willing-provider statute undermines the ability of an insurer-administered PPO to operate effectively. Shorn of the right to select and limit the number of participating providers, such PPOs are unable to guarantee a higher patient volume. Consequently, they are unable to obtain lower prices for their subscribers. By depriving insurer-administered PPOs of the right to choose the health care providers in their PPOs, and by forcing such PPOs to make their subscribers available to any willing provider, the Virginia statute at issue destroys the economic incentives for either subscribers *or* providers to join these PPOs. The Fourth Circuit's conclusion that such a statute is not preempted thus thwarts ERISA's goal of facilitating efficient, nation-wide employee benefit programs.

The Fourth Circuit arrived at its erroneous conclusion by misconstruing the phrase "business of insurance" and determining that the Virginia statute was "saved" from preemption. In fact, Virginia's any-willing-provider statute does not satisfy any of the three requirements established by this Court for determining whether a regulation governs the "business of insurance." The Virginia law does not affect the spreading of a policyholder's risk; it is not an integral part of the policy relationship between the insurer and the insured; and it is not limited to entities within the insurance industry. The Virginia statute regulates the business of insurance companies, not the "business of insurance." It is therefore preempted by ERISA.

Congress's present consideration of health care reform proposals, most notably that of President Clinton, underscores the need for the Court to review this case. Almost all of the health care plans under review would rely heavily on PPOs. Thus, the question as to whether state laws such as any-willing-provider statutes are preempted will remain, especially because none of the primary proposals currently under consideration would modify the scope of ERISA preemption and the insurance savings clause. In any event, health care reform legislation probably would not be effective for many years. During that extended interim period, any hope that health insurers will be able to control their premium increases must rest on their ability to create efficient and competitive health care programs such as PPOs. Thus, in light of the important social value of PPOs and the critical questions of law presented here, this Court should grant certiorari.

REASONS FOR GRANTING THE WRIT

I. ANY-WILLING-PROVIDER STATUTES DESTROY THE ABILITY OF PREFERRED PROVIDER ORGANIZATIONS TO CONTROL HEALTH CARE COSTS.

This case presents an issue of true national significance. Preferred provider organizations ("PPOs") are an increasingly popular and cost-effective mode of managed health care that has developed recently in response to the severe national problem of escalating health care costs. PPOs are more frequently organized by a non-insurance entity—only 36 percent of PPOs are administered by insurers. The organizing entity enters into contracts with selected hospitals, physicians, and other health care providers. These providers agree to supply services to the PPO's subscribers in accordance with certain standards established by the PPO, most notably relating to price and quality of care. In exchange for furnishing health care to these subscribers on the PPO's terms, the providers obtain either a higher or more secure flow of patients.

The Fourth Circuit's erroneous determination that any-willing-provider statutes are not preempted undercuts the rights of an insurer-administered PPO to select the health care providers it believes can meet its standards, as well as its ability to attract health care providers into its PPOs. Thus, at best, the Fourth Circuit's decision would effectively bar insurance companies from organizing PPOs; at worst, it will eventually frustrate the recognized social utility of PPOs. Eliminating insurer-administered PPOs would cripple the PPO market and disrupt the lives of many PPO participants. In the United States, 54 percent of all PPO subscribers are in PPOs administered by health insurance companies. Marion Merrell Dow, *Managed Care Digest: PPO Edition*, at 7 (1992) [hereinafter "*Managed Care Digest*"]. These several million individuals would be forced to find alternative health benefit plans if insurer-administered PPOs were effectively barred. This Court should grant the writ of certiorari to resolve this issue of profound national importance.[1]

A. PPOs Have Increased Rapidly in Popularity Because They Have Helped To Control Health Care Costs in the United States.

All PPOs share certain characteristics. In its simplest form, a PPO is an intermediary between two groups: subscriber health care recipients and selected health care providers. The PPO organizes health care recipients—usually through large employers—and contracts with the recipients for the payment of premiums. The PPO also selects health care providers that are able to meet its desired terms and restrictions in providing care. The PPO sets a range of discounted rates at which the participating providers must supply their medical services. In return for these lower prices offered by the providers, the PPO guarantees higher patient volume to the providers.[2]

[1] In addition, *amici curiae* adopt by reference the arguments for granting the writ of certiorari set forth in the Petition for Writ of Certiorari filed by Aetna.

[2] *See, e.g.*, David Dranove et al., *The Effect of Injecting Price Competition Into the Hospital Market: The Case of Preferred*

The PPO covers entirely the costs of PPO subscribers in need of medical services who seek care from a PPO-participating provider, except for a small subscriber co-payment (or deductible). If, however, the subscriber wishes to use a non-PPO participating provider, the PPO pays for a lower percentage of the medical expenses instead of the entire amount. *See, e.g.*, David Dranove et al., *The Effect of Injecting Price Competition Into the Health Market: The Case of Preferred Provider Organizations*, 23 Inquiry 419, 421 (1986); H.E. Frech III & Paul B. Ginsburg, *Competition Among Health Insurers, Revisited*, 13 J. Health Pol. Pol'y & L. 279, 284 (1988). Thus, the PPO creates a financial incentive for its subscribers to use PPO-selected providers, although they retain a free choice of providers. Many individuals, when choosing a new doctor or getting a referral, select one from the list of providers designated by the PPO, leading to increased patient volume for the PPO-participating providers.

The popularity of PPOs has continually increased since their introduction in the early 1980s.[3] The number of PPOs in the United States has grown almost ten-fold, from 115 in 1984 to 1036 in 1992. American Association of Preferred Provider Organizations, *PPO Growth (1984-1992)*, at 1 (June 1993). Similarly, in the five years between 1987 and 1992, the numbers of Americans participating in PPOs has risen from 12 million subscribers

Provider Organizations, 23 Inquiry 419, 420-21 (1986); H.E. Frech III & Paul B. Ginsburg, *Competition Among Health Insurers, Revisited*, 13 J. Health Pol. Pol'y & L. 279, 284 (1988); Thomas L. Greaney & Jody L. Sindelar, *An Assessment of the Anticompetitive Effects of Preferred Procider Organizations*, 24 Inquiry 384, 384-85 (1987).

[3] Notably, PPOs were not initially created by insurance companies, but rather by small independent firms. *See* Frech & Ginsburg, *supra*, at 289; *see also* Marci A. Firfer, *Direct Employer-Provider Contracting and ERISA Preemption: A Regulatory Loophole?*, 10 Fed'n Ins. & Corp. Couns. Q. 195, 203-04 (1990) (noting the rapid increase in PPOs since their "invention" in the early 1980s).

to 58 million. *Id.* Insurer-administered PPOs cover over 30 million individuals nationwide—54 percent of all current PPO subscribers. *Managed Care Digest, supra,* at 7.

The growth of PPOs is directly attributable to the benefits that PPOs provide to all participants and society as a whole. *See, e.g.,* Frech & Ginsburg, *supra,* at 284; Thomas L. Greaney & Jody L. Sindelar, *An Assessment of the Anticompetitive Effects of Preferred Provider Organizations,* 24 Inquiry 384, 384 (1987). In particular, PPOs have helped control overall health care costs by promoting price competition among providers. Because PPOs represent numerous health care recipients, they have substantial negotiating power. As a result, PPOs negotiate discounts in physician fees by a national average of 20 percent, and discounts in hospital costs averaging 17 percent nationally. *Managed Care Digest, supra,* at 36; Glenn A. Melnick et al., *The Growth and Effects of Hospital Selective Contracting,* 14 Health Care Mgmt. Rev. 57, 60 (1989).[4]

PPOs thus benefit patients greatly. PPO participants have lower out-of-pocket costs, yet they retain the freedom to choose physicians outside of the PPO network as well as providers within the network. *See, e.g.,* Dranove et al., *supra,* at 421; Greaney & Sindelar, *supra,* at 384-85.[5] Furthermore, because a PPO has greater resources than individual consumers, PPOs supply more information about providers and costs than is generally accessible

[4] PPOs promote the efficient use of medical resources through "utilization review," a mechanism whereby the PPO reviews the use of medical resources by hospitals and doctors to determine whether a procedure was necessary. Through utilization reviews, PPOs inhibit "moral hazards" *i.e.*, overconsumption and unnecessary use of medical resources that may occur because a health care recipient has a low "out-of-pocket" expense.

[5] The freedom to choose non-participating providers does not exist with most health maintenance organizations ("HMOs"). Unlike the case with PPOs, HMO subscribers who seek services from a non-participating provider must pay the full cost for those services.

to individuals. Where an individual consumer may not have the time or resources to investigate the quality or reputation of particular doctors, a PPO—through its selection of providers—can essentially serve as a "Good Housekeeping Seal of Approval" with respect to the competence of the health care provider. Thus, many PPO subscribers rely on the PPO's inclusion of a doctor in the network as an indication of that doctor's capabilities.

More generally, the increased information PPOs provide allows individual consumers to make more educated decisions about their particular health care needs. Greater consumer knowledge increases the competitiveness of the market, as providers are forced to respond to consumer needs. *See, e.g., Economic Report of the President* 139-40 (January 1993); Paul B. Ginsburg & Glenn T. Hammons, *Competition and the Quality of Care: The Importance of Information*, 25 Inquiry 108, 110-13 (1988). Claims to PPOs also involve far less paperwork than "traditional" health insurance.

PPOs benefit not only consumers, but also providers. For providers, participation in a PPO network guarantees a steady patient volume. Providers also have an incentive to strive for efficiency and quality care in order to compete with other providers and to meet the standards established by the PPO. Unlike the case with HMOs, however, PPO-participating providers need not reorganize their practice. Services are still provided on a "fee-for-service" basis, and providers do not assume the financial risk involved with HMO membership. *See, e.g.*, Ginsburg & Hammons, *supra*, at 109; Greaney & Sindelar, *supra*, at 385.[6] In addition, the turnaround time for claims is decreased because participating providers generally deal with fewer payor organizations.

[6] Because the payment an HMO makes to a provider is fixed, the risk that a particular patient or group may need more medical attention than usual, and thereby consume the doctor's resources, shifts to the doctors. *See, e.g.*, Frech & Ginsburg, *supra*, at 284; Greaney & Sindelar, *supra*, at 385-86.

PPOs also benefit society at large. PPOs have led to a reduction in the average hospital stay, the use of more outpatient procedures, a reduction in the inefficient and costly surplus of hospital beds, and an overall reduction in the number of unnecessary procedures. *See, e.g.*, Dranove et al., *supra*, at 420-21, 427-28; Lucy Johns, *Selective Contracting in California: An Update*, 26 Inquiry 345, 346-49 (1989). In the most comprehensive study of the effects of PPOs, which was conducted in California, researchers found that examination of different factors "all show that the [selective contracting] policy produced measurable cost containment." Johns, *supra*, at 345. For example, the average length of hospital stay for patients dropped by 2.9 percent in five years, and the rates of growth in gross medical expenses decreased significantly as well. *Id.* at 346-47. Furthermore, a number of services that can be conducted either on an inpatient or outpatient basis are increasingly performed without hospitalization. *Id.* Since the introduction of PPOs, the overall hospital expense per admission in California, the state with the largest number of PPOs in the nation,[7] has been consistently lower than that of the rest of the nation. Melnick et al., *supra*, 14 Health Care Mgmt. Rev. at 62. In 1986, the percent of per capita income spent on hospital services declined in California, while increasing in the rest of the nation. *Id.* Perhaps most importantly, Commentators estimate that the increase in the number of PPOs[8] has resulted in a 24-percent discount in medical services for PPO participants. *See* Dranove et al., *supra*, at 421.

Almost all health care commentators agree that results like those exhibited in California can be expected nationwide as PPOs increase. "[B]ecause PPOs can promote

[7] California has a total of 104 PPOs. Marion Merrell Dow, *Managed Care Digest: PPO Edition*, at 10 (1992).

[8] From 1984 to 1988, the number of PPOs in California increased from 37 to 72, and the number of enrollees increased from 430,000 to 16.8 million. Lucy Johns, *Selective Contracting in California: An Update*, 26 Inquiry 345, 351 (1989).

cost containment, improve market competitiveness, and produce positive externalities, public policies should promote the development of PPOs." Greaney & Sindelar, *supra*, at 389; *see also* Frech & Ginsburg, *supra*, at 289 ("public officials have generally applauded the degree of innovation in the private financing of health care"). The social utility of PPOs as effective health care delivery systems is therefore both quantifiable and substantial.

B. By Eliminating the Ability of Preferred Provider Organizations To Choose Providers in Their Plans, Any-Willing-Provider Statutes Destroy the Ability of PPOs To Control Health Care Costs.

Virginia's any-willing-provider statute, and similar laws of other states, prevent insurer-administered PPOs from selecting the provider-members of their PPO—the fundamental principle necessary for a PPO to operate effectively.[9] The application of the Virginia statute to insurer-administered PPOs creates "considerable inefficiencies in benefit program operation," *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987), thereby thwarting Congress's purpose in enacting ERISA to preempt employee benefit plans from state regulations. *See FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the admin-

[9] The Virginia statute states, in relevant part:

> Any . . . insurer [forming a PPO] shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. . . .

Va. Code Ann. § 38.2-3407 (Michie 1993).

istration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.").

Opening PPOs to all providers that evince a willingness to meet the PPO's established terms and conditions diminishes the cost savings associated with such arrangements to the point where the economic incentives for both providers and subscribers to join a PPO are entirely dissipated. Too many health care providers in a PPO renders it incapable of guaranteeing a narrower group of chosen providers higher patient volume. Without any concrete benefit, hospitals and doctors are unable and unwilling to offer discounted rates. In the absence of lower rates, subscribers would not join a PPO.

Stated differently, limiting the number of providers in a PPO is essential to the PPO's ability to remain cost-effective. Studies show that there is an optimal number of providers for any given PPO in a geographical location. *See, e.g.*, Wyatt Company, *Report to Health Insurance Association of America*, at 15 (June 7, 1991) [hereinafter "*Wyatt Report*"]. Up to that number, a PPO will enjoy the economies of scale, and the increased negotiating power associated with size. These benefits will outweigh any administrative inefficiencies created by size, and would result in lower prices for consumers. Beyond that point, however, the marginal benefit of an additional provider exceeds the cost associated with increased membership. *Id.; see also* Glenn A. Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217, 229-30 (1992).[10]

In a 1991 study, researchers concluded that any-willing-provider statutes could increase administrative costs between 34 and 52 percent, and increase the cost of claims from 8.8 to 14.2 percent. *Wyatt Report*, at 4-5. These increased costs more than consume the hospital discounts

[10] In addition, without a competitive health care market, PPOs lack the incentives to ensure high-quality and low-cost service, or to provide accurate information to subscribers for use in making educated choices concerning health care.

of 17 percent and physician discounts of 20 percent that PPOs are able to derive on average. Thus, any-willing-provider statutes plainly destroy the ability of PPOs to contain health care costs.

Furthermore, the study noted that "reasonable" statewide provider selection criteria, such as those mandated by the Virginia statute, probably could not eliminate enough providers from the PPO to allow efficient utilization of selective contracting. *Id.* at 5. Rather, so many doctors and hospitals would have a "right" under the state statute to participate in the PPO that the costs savings necessary to justify entering into PPO agreements could not be attained. Thus, the existence of any-willing-provider statutes is fundamentally incompatible with that of insurer-administered PPOs.

The imposition of "reasonable" provider selection provisions impairs the effectiveness of PPOs because the criteria used by PPOs to screen providers is by necessity highly flexible and includes more than just so-called "objective" criteria.[11] PPOs must be free to make "arbitrary" judgments in selecting providers if they are to reach the optimal number of providers. For example, even if two providers are identical in quality and conventional price, a PPO that has reached its limit cannot be forced to allow both to participate. Mandating that both providers be allowed to join the PPO expands provider participation beyond the point of economic efficiency. Rather, a PPO must be allowed to choose between the two providers, even if on an "arbitrary" basis such as competitive bidding.

PPOs must also consider subjective factors as well as objective ones. These subjective criteria, such as percep-

[11] Such objective criteria include, in the case of hospitals, financial factors such as per diem rates, comparison to cost and charges at other hospitals in the service area. Quality selection criteria will often also include professional staff-to-patient ratio, malpractice history, percentage of staff physicians who are board certified, and accreditation status.

tions in the community, customers' relationships with hospital staff, financial stability and viability (including the cushion from charitab'e donations and tax base), and willingness to abide by rules of the managed care agreement, are not easily defined in the terms and conditions of a contract between the PPO and participating providers. Yet these factors are critical in determining which providers fit into the profile and philosophy of an individual PPO. *See, e.g.*, Ginsburg & Hammons, *supra*, at 110-13 (consumer opinions about a provider's quality of care in comparison to cost and its community reputation significantly affect individual decisions with respect to health care); Ezekiel J. Emanuel & Allan S. Brett, *Managed Competition and the Patient-Physician Relationship*, 329 New Eng. J. Med. 879, 880-82 (1993) (individual patient-physician relationships and continuity of care may affect health care choices even in managed competition). Any-willing-provider statutes severely constrain the ability of insurer-administered PPOs to select providers on the basis of these critical criteria, and to ensure that the providers continue to supply the type of care the PPOs seek to deliver.[12]

Not surprisingly, commentators and researchers uniformly criticize the application of any-willing-provider statutes to PPOs. *See, e.g.*, Greaney & Sindelar, *supra*, at 389 ("A primary blockade has been and continues to be state laws that prohibit selective contracting and that limit efficient contracting. We suggest that such laws be eliminated to allow for the growth of PPOs."); *Wyatt Report*, *supra*, at 5 ("th[e] legislative mandate [in any-willing-provider statutes] would eliminate the value of that PPO to the community"). Indeed, the purpose of these statutes is directly contrary to the principles of selective

[12] The quality of care maintained by a provider after the provider enters the network is important and cannot be defined in terms of the contract. Although the PPO may terminate its contract with a provider if the quality diminishes, a PPO would rather exclude providers it deems unacceptable from participation in the PPO in the first place. Dranove et al., *supra*, at 428.

contracting which underlie the effectiveness of PPOs. Thus, any-willing-provider statutes frustrate the development of PPOs as a mechanism for combatting escalating health care costs.

II. INSURANCE COMPANY ADMINISTRATION OF A PREFERRED PROVIDER ORGANIZATION DOES NOT CONVERT A PPO INTO THE "BUSINESS OF INSURANCE".

Notwithstanding the social value of PPOs and the dangers presented by any-willing-provider statutes, the Fourth Circuit erroneously held that insurer-administered PPOs must comply with the Virginia statute because it is not preempted by ERISA. That decision misinterpreted the meaning of the phrase "business of insurance" and, in the process, created several conflicts with this Court's prior decisions and with decisions from other circuits.

ERISA preempts all state laws that "relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1988). Any state statute that "regulates insurance," however, is saved from preemption. *Id.* § 1144(b)(2)(A). This Court has stated that whether a statute "regulates insurance" is guided by the same criteria used to determine whether an entity is engaged in the "business of insurance," as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. § 1011 (1988). *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). In interpreting these terms, the Court has recognized that Congress intended ERISA preemption to be very broad. *See, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990); *Metropolitan Life*, 471 U.S. at 739; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97-98 (1983).[13]

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[13] The legislative history confirms ERISA's wide scope of preemption. As stated by one Representative during the House debates:

> I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans.

Selective contracting by PPOs is part of the "business of insurance companies," not the "business of insurance." *See, e.g., Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, 2902 (1993); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 233 (1979). It is the mechanism by which the PPO controls administrative costs and procures the efficient delivery of health care. Just as agreements made with retail pharmacists are unrelated to the "business of insurance" because pharmacists are "parties wholly outside the insurance industry," agreements made with hospitals, doctors, and other health care providers likewise should not be considered the "business of insurance." *See Royal Drug*, 440 U.S. at 231-33; *see also Hartford Fire Insurance Co.*, 113 S. Ct. at 2902.

A recent decision by this Court highlights the Fourth Circuit's error. As was recognized in *Hartford Fire Insurance Co.*, " 'the business of insurance' should be read to single out one *activity* from others, not to distinguish one *entity* from another." *Id.* at 2901 (emphasis added). In contravention of this mandate, the Fourth Circuit relied on Aetna's status as an insurance entity rather than focusing on the pertinent activity. The Fourth Circuit thus "draws a broad and illogical distinction between benefit plans that are funded by [non-insurance companies] and those that are insured by regulated insurance companies." *EMC Corp.*, 498 U.S. at 65 (Stevens, J., dissenting). The disparate treatment of insurer-administered PPOs is further evidence of the "patchwork scheme of regulation" sought to be avoided under ERISA to prevent "considerable inefficiencies in benefit program operation."

With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); *see also id.* at 29933 (remarks of Sen. Williams) ("[ERISA preemption] is intended to apply in its broadest sense to all actions of State or local governments"); H.R. Rep. No. 1785, 94th Cong., 2d Sess. 47 (1977) ("[T]he Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.").

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987).[14]

Moreover, in considering whether a statute regulates the "business of insurance," this Court has said that the activity regulated must satisfy three requirements:

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982), *quoted in Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). All three factors must be satisfied for a regulated activity to be considered the "business of insurance." The Fourth Circuit's decision, however, contorts these three factors in order avoid ERISA preemption. In so doing, the lower court has impermissibly re-written the meaning of the "business of insurance."

Unlike insurance contracts, PPO agreements with health care providers do not "transfer[] or spread[] a policyholder's risk." *Pireno*, 458 U.S. at 129; *accord Metropolitan Life*, 471 U.S. at 743. A health insurer contracts to pay for an insured's medical services in return for a fixed premium. That premium is calculated by equalizing the known, but unpredictably distributed, medical costs incurred by the consumers (policyholders) within the risk pool. *See, e.g.*, Frech & Ginsburg, *supra*, at 279. Thus, through actuarial science, health insurers are able to respond to the random catastrophes of individual life precisely because, on a large scale, the frequency of such

[14] *See also Travelers Ins. Co. v. Cuomo*, No. 93-7132L, slip op. at 29 (2d Cir. Oct. 25, 1993) ("Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans . . . . The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.").

events becomes reasonably predictable. *See generally* Robert E. Keeton & Alan I. Widiss, *Insurance Law* 12-13 (1988).

A PPO's dealings with health providers do not serve the role of "risk pooling." In their interactions with providers, PPOs do not categorize risks, predict their frequency, or determine coverage for certain risks. The choice of providers for participation in a PPO is wholly unrelated to the calculation of risk. Similarly, neither the number of providers participating in a PPO nor the terms and conditions imposed on participating providers will affect the probability of a health care claim for which the PPO must pay. *See* Marci A. Firfer, *Direct Employer-Provider Contracting and ERISA Preemption: A Regulatory Loophole?*, 40 Fed'n Ins. & Corp. Couns. Q. 195, 216 (1990) ("a PPO is *not* a traditional indemnity insurance plan" (emphasis in original)); *id.* at 235 ("[T]he concept of insurance typically includes both the accumulation and distribuiton of a fund, and the transfer of risk. A PPO does neither."). Rather, these dealings are between the PPO and providers, not the PPO and individual health care recipients or their payers.

Thus, the Fourth Circuit's overly expansive definition of a "policyholder's risk" is in clear error. App. 9a-10a. Treating all statutes relating to the type and cost of treatment available to a subscriber as within the defiintion of a "policyholder's risk" would subject almost all business decisions made by insurer-administered PPOs to state law. Accordingly, the Virginia statute does not satisfy the first criteria set forth by this Court because selective contracting does not have "the effect of transferring or spreading a policyholder's risk." *Pireno*, 458 U.S. at 129; *accord Metropolitan Life*, 471 U.S. at 743.

The statute also fails the second prong of the *Pireno* test, because it is not "an integral part of the policy relationship." *Pireno*, 458 U.S. at 129. In *Royal Drug*, this Court recognized that only agreements between the insurer and the insured were a part of the policy relation-

ship. *Royal Drug*, 440 U.S. at 215-16. "So long as th[e] promise [made between the subscriber and the intermediary] is kept, policyholders are basically unconcerned with arrangements made between [the intermediary] and participating [providers]." *Id.* at 214.

Finally, the Virginia statute fails the third prong of the *Pireno* test. As noted, the practice of organizing and administering PPOs was initially undertaken by third-party administrators and small investment companies, not insurance companies, *see* Frech & Ginsburg, *supra*, at 289, and the "insurance industry" owns only 36 percent of the existing PPOs nationwide. *See Managed Care Digest*, *supra*, at 7. As such, it is plainly meritless to contend that "the [PPO] practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743. Accordingly, because PPOs meet none of the Court's cirteria for determining what constitutes the "business of insurance," the Fourth Circuit incorrectly held that the any-willing-provider statute was "saved" from ERISA preemption.

The Fourth Circuit's reasoning that the statute regulated the business of insurance simply because "[i]t is part of a comprehensive code regulating accident and sickness insurance," App. 9a, directly conflicts with the Fifth Circuit's decision in *Tingle v. Pacific Mutual Insurance Co.*, 996 F.2d 105 (5th Cir. 1993).[15] In *Tingle*, the Fifth Circuit stated that "the mere fact that a statute is part of a comprehensive state insurance code will not exempt it from preemption." *Id.* at 109.[16] In this respect as well,

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[15] In addition to *Tingle*, the Fourth Circuit's decision conflicts with *Ticor Title Insurance Co. v. FTC*, 998 F.2d 1129 (3d Cir. 1993), as well as a decision from its own circuit, *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). *See* Petition for Writ of Certiorari filed by Aetna at 22-24, 25-26.

[16] *See also Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991) (ERISA preemption of statute included in the Texas Insurance Code); *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760, 763-64 (5th Cir. 1989) (same); *Anschultz v. Connecticut*

the Fourth Circuit erred and created an intercircuit conflict that can only be resolved by this Court.

III. CURRENT CONSIDERATION BY CONGRESS OF HEALTH CARE REFORM DOES NOT ELIMINATE THE NEED FOR THE COURT TO REVIEW THIS CASE.

The present consideration by Congress of health care reform is not a basis for denying certiorari. Indeed, that circumstance militates in favor of granting the writ of certiorari so that the important issues of state-federal relations posed can be clarified as new health care arrangements are considered and potentially implemented. Even if President Clinton's health care reform proposal were adopted *today*, the ill effects of the Fourth Circuit's erroneous decision would remain. Accordingly, resolution of this case by the Court is necessary because: (1) PPOs would continue to exist under most of the proposed plans, and the question as to whether federal law preempts state regulations such as any-willing-provider statutes will remain; (2) even if adopted this year, none of the current health care plans under consideration would take effect for quite a long time, and calls for interim measures to control health care costs during the transition will exacerbate the need to vest insurance companies with the ability to choose providers; and (3) the Fourth Circuit decision creates unnecessary confusion as to this Court's jurisprudence concerning the "business of insurance."

First, and foremost, President Clinton's proposal, like many others, calls for the establishment of regional and corporate health alliances, whereby "[e]ach alliance offers a menu of plans, including a traditional fee-for-service arrangement, *preferred provider organizations* and health maintenance organizations." The White House, *Health Security Preliminary Plan Summary* 19 (1993) (emphasis added); *accord id.* at 23. Furthermore, none of the major proposals currently under consideration contemplate

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General Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988) (ERISA preemption of statute included in the Florida Insurance Code).

amending ERISA's insurance savings clause in a manner which would affect the question presented by this case. *See, e.g., Clinton Administration Description of President's Health Care Reform Plan, "American Health Security Act of 1993"*, Health L. Rep. (BNA) S-24, at 71-72 (Sept. 16, 1993).[17] Thus, PPOs would still compete in any new health care plan, but whether they would be subject to state insurance laws would, it seems, still be governed by the ERISA provisions at issue here. Accordingly, the importance of resolving this issue extends beyond the passage of any health care reform package.[18]

In addition, health care reform, even if adopted by Congress immediately, will not be implemented until at least 1997. In fact, most commentators doubt that any health care plan will be implemented much before the turn of the millennium. *See, e.g., Two Plans and Where They Might Lead*, Wall St. J., Sept. 23, 1993, at A8; *Shouting Matches: Six Areas of Dispute*, Newsweek, Oct. 4, 1993, at 49. And, for any transition period, the Presi-

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[17] *See also, e.g., Health Care: Clinton's Plan and the Alternatives*, N.Y. Times, Oct. 17, 1993, at 22; *Two Plans and Where They Might Lead*, Wall St. J., Sept. 23, 1993, at A8; *Shouting Matches: Six Areas of Dispute*, Newsweek, Oct. 4, 1993, at 49 (describing the main alternative proposals to the Clinton plan). The only bill that would affect state regulation of PPOs is H.R. 3222, introduced by Representative Cooper. Recognizing the problems posed by any-willing-provider statutes, the Cooper bill provides that "[a] State may not prohibit or limit a network plan from limiting the number of participating providers." H.R. 3222, § 1222(a)(4). This bill, however, is generally considered unlikely to pass, and none of the other proposals contemplate a similar amendment.

[18] In addition, the Clinton proposal, and the main alternatives, all rely on managed competition to drive down costs. "The Health Security plan controls rising costs and improves the quality of health care by enlisting the power of a competitive market and empowering consumers to make choices that suit their needs." The White House, *Health Security Preliminary Plan Summary* 14 (1993). Because any-willing-provider statutes interfere with market competition, these plans further support the view that PPOs and selective contracting programs constitute sound public policy.

dent has proposed controlling escalating health care costs by tightly regulating insurance premium increases. *See* Dana Priest, *Insurance Curbs Asked for Interim*, Wash. Post, Sept. 27, 1993, at A1. To maintain proper financial stability during this time, insurance companies must be able to administer programs like PPOs in a manner which would contain costs.

Finally, the Fourth Circuit's decision misapplies and unnecessarily confuses the jurisprudence defining the "business of insurance." This definition applies to ERISA preemption independent of the health care proposal, and is also employed in the McCarran-Ferguson Act. Thus, cases such as this, distinguishing between the "business of insurance" and the "business of insurance companies," are important regardless of their relation to health care reform legislation.

CONCLUSION

For all of the foregoing reasons, the Court should grant the petition of Aetna Life Insurance Company and Aetna Health Management, and set the case for plenary review.

Respectfully submitted,

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